


APRETUDE (CABOTEGRAVIR) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

 option care health®	Patient Name:		Date of Birth:	
	Address:			
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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If New to Therapy, will patient be started on oral lead-in of Vocabria (cabotegravir)?

- No Yes- recommend oral lead-in should **NOT** be started until any applicable Apretude payor authorization has been secured

If Yes, has patient started oral lead-in of Vocabria (cabotegravir)?

- No – Upon securing applicable prior authorization, Option Care Health will follow-up with prescriber to coordinate oral lead-in
 Yes – Start Date: _____

If Continuing Therapy, date of last injection (if known): _____ Date of next injection: _____

Apretude (Cabotegravir) Prescription

Apretude (Cabotegravir)

- Initiation Dose:** Nurse to administer cabotegravir 600 mg via intramuscular injection monthly x 2 months. If oral lead-in is used, injection should be administered on the last day of oral lead-in (28 days) or within 3 days thereafter. Discontinue oral lead-in after Apretude administration. Dispense Apretude 600 mg kit x 1 dose with refills x 1
- Maintenance Dose:** Nurse to administer cabotegravir 600 mg via intramuscular injection every 2 months (+/- 7 days to allow for patient/nurse scheduling) beginning 2 months after completion of initiation doses. Dispense Apretude 600 mg kit x 1 dose with refills x 1 year.

NOTE: Individuals must be tested for HIV-1 infection prior to initiating Apretude and with each subsequent injection of Apretude. Option Care Health will only accept an RNA-specific assay results within 7 days prior to administration.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

- Yes No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500mL (>30kg) or 250mL (≤30kg) IV at KVO rate PRN anaphylaxis. Patients ≤30kg, infuse over 2 to 4 hours PRN headache rated >5 on pain scale.

Pre-Medication Orders

- Other: _____

Lab Orders

- No labs ordered at this time
 Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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